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Attorney for Defendant  
George Thomas

UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF CALIFORNIA  
OAKLAND DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

v.

GEORGE THOMAS,

Defendant.

NO. 4:24 CR 00384 - HSG

DEFENDANT GEORGE THOMAS'  
SENTENCING MEMORANDUM AND  
COMMENTS TO PRESENTENCE REPORT  
AND PLEA AGREEMENT.

December 11, 2024, at 1:30 p. m.

**PAST BEHAVIOR IS NOT PROLOGUE IN MR. THOMAS' CASE:**

This Sentencing Memorandum is respectfully submitted on behalf of Mr. George Thomas, in advance of his sentencing hearing on December 11, 2024.

Mr. Thomas stands before the court having agreed to plead guilty to one count of the Information charging him with possession of child pornography in violation of 18 U.S.C. §§ 2252(a)(4)(B) and (b)(2). Since his arrest, Mr. Thomas has wisely spent his pre-trial time productively, monitored, on supervised released, with adequate work-home detention as part and parcel of his remorse. He truly has appreciated the mandatory opportunity to attend court ordered therapy sessions while searching and learning of available rehabilitation options. Hence, Mr. Thomas felt it better to waive

1 prosecution by indictment, waive trial, including unburdening the Government and  
2 Court from having to prove the elements of the crime. Mr. Thomas also freely waived  
3 appeal against any aspect of his sentence, while reserving his right only to claim that his  
4 6<sup>th</sup> Amendment counsel was ineffective.

5 Mr. Thomas admits possessing materials he knew contained visual depictions of  
6 minors engaged in sexually explicit conduct. Mr. Thomas took no part in the production  
7 of such matter, nor profiteering from it, together with never or since engaging in any  
8 physical sexual conduct on any level, at any time, with any male or female of any age,  
9 in his entire life. His revelation of non-voluntary, sexual non-existence was learned  
10 early in run-up to a change of plea. It was a sign Mr. Thomas quite possibly falls  
11 outside the full scope of punitive punishment by incarceration.

12 Consideration is acknowledged of the influence of pre-determined sentencing  
13 guidelines and the factors set forth in 18 U.S.C. § 3553(a). That is, the imposition of  
14 enough punishment but not more than necessary being the normal precept and challenge  
15 in sentencing. Consider Mr. Thomas has lived through enough punishment and daily  
16 angst that has progressively troubled his character throughout his life and for which he  
17 is neither fully responsible nor criminally to blame.

18 The following psychological summary of findings, reliable tests, consideration of  
19 family history, and diagnoses are recorded and explained in the attached November 23,  
20 2024, forensic evaluation authored by Dr. Natalie Sobel.

21  
22 “Available data suggests the presence of attention deficit  
23 hyperactivity disorder and unspecified neurodevelopmental disorder.  
24 Mr. Thomas also meets diagnostic criteria for various moods, anxiety,  
25 and personality disorders. Certain vulnerability and destabilizing  
26 factors are relevant specifically to Mr. Thomas’ offending behavior.  
27 Mr. Thomas expresses remorse and has taken notable steps toward  
understanding and treating his pornography addiction.”

Mr. Thomas was subsequently referred to Dr. Nicole Vienna, Psy.D. for an assessment to rule out autism spectrum disorder. In sum, Dr. Vienna further investigated Mr. Thomas' speech and communication deficits, avoidance of social interactions, and difficulty making and maintaining friendships with standardized testing and further interview/evaluation. Among Dr. Vienna's observations were the presence of language deficits, significant anxiety, sensory issues (including being sensitive to fabric, textures, and overwhelming sounds), and some restricted/fixated interests. Mr. Thomas would benefit from a psychotropic medication evaluation to target his mood and anxiety symptoms. Finally, Mr. Thomas should complete Dr. Vienna's recommended cognitive/neuropsychological testing to assess his informational processing abilities and better understand his cognitive strengths and weaknesses.

**RESPONSES THAT SIGNAL FURTHER INQUIRY:**

During our pre-trial assessment process, Mr. Thomas was vetted in regular order. The information he provided triggered other directions and probabilities in assessing his general culpability that is likely outside the sentencing guideline metrics. The inquiry was astonishingly and self-evident:

*Q: "At what age did you become sexually active? With whom? How old was your partner? Was the sexual activity consensual?"*

***GT: "I have not had any sexual partners. neither consensual nor non-consent. neither with male nor female partners. no one."***

*Q: "Have you ever masturbated to images or videos of child pornography, bestiality, sadomasochism, voyeurism, fetishism, sadism, etc.?"*

***GT: "No. No sexual partners, ever. Universally, no."***

1  
2 *Q: “Who have you had sex with: men, women, or both? Is your*  
3 *family aware of your sexual orientation? Are they supportive? Are you*  
4 *currently sexually active? Please describe. If no, when was your last*  
5 *sexual encounter? How many sexual partners do you currently have?*

6 *GT: “I have not had any sexual partners. Neither with male or*  
7 *female partners. None. I have not shared any aspect of my sex*  
8 *orientation. I have no sexual partners currently or ever in the past. None.*  
9 *there was no such relationship. no relations or contact, neither one-to-*  
10 *one, or in any manner tactile or via communication medium in real-time*  
11 *or remotely, with any person, at any time.*

12 *Q: “Have you ever used alcohol, drugs, or prescription or*  
13 *natural remedies to enhance your sexual function?”*

14 *GT: “No. I have never been stress-free socially and never turned*  
15 *to alcohol, drugs, or holistic remedies with hope to reduce my stress-*  
16 *coping. Therefore. No, I never use alcohol or drugs.”*

17 *Q: “How would sex offender treatment benefit you?*

18 *GT: “I am diagnosed with Adult ADHA. Treatments ordered by*  
19 *pre-trial services prompted further health care tests for possible autism*  
20 *spectrum tests which result is also positive (as does his brother and*  
21 *nephew). I have not had sex with anyone. The treatment sessions ordered*  
22 *by pre-trial services are very helpful and have helped me to self-reduce*  
23 *my stresses and choices.*

24  
25 Mr. Thomas has no criminal history. No juvenile justice involvement. His  
26 personal traits and motivations are low risk of reoffending. He is highly compliant and  
27 will follow treatment plans to the letter. He has certain diagnosed permanent mental

1 health disorders that contribute to someone who has severe difficulty processing what is  
2 real versus unfamiliar. Mr. Thomas' autism is instrumental in mitigating culpability.

3  
4 **PERSONAL FAMILY STATS:**

5 Mr. Thomas' mother died March 15, this year, a month prior to his arrest. She  
6 had heart murmur since birth and later developed high blood pressure then on  
7 medications for life. She divorced George's father, leaving both George and his brother  
8 Kenny with their mother. Father paid mother barely enough money to keep their heads  
9 above water.

10 Mr. Thomas does not have a childhood memory of his father's work. His father  
11 was married to George's mother for 25 years. George was traumatized and childhood  
12 depressed from parents constant fighting. Father remarried to a woman with several of  
13 her own children. His Stepmother always treats George well. His father does not  
14 provide George much emotional support and was always too distant or not at all for  
15 many years. George's brother lives in Washington State. George never visited  
16 Washington State to see his brother's wife and children. George's mother loved talking  
17 to the granddaughters on FaceTime. George's only family and cousin live close. About  
18 10-15 minutes. George sees them every week.

19  
20 **GUIDELINES ARE NOT A RELIABLE METRIC IN THIS CASE:**

21 Federal Sentencing of Child Pornography Non-Production Offenses was  
22 published in June 2021, by U.S. Sentencing Commission. Based on a 10-year follow-up  
23 study of all federal underlying offenders in every non-production pornography  
24 conviction, one-in-three offenders engaged in physical real-time sexually abusive  
25 conduct upon a person, in addition to the child pornography offense committed  
26 remotely via proliferation of computers and internet-based technology. One-in-Three  
27 Offenders is significant enough stat to create sentencing disparity that fails to

distinguish these offenders as having completely different degrees of culpability yet are subject to the same punitive guidelines. Mr Thomas in this respect does not fit the general child pornography statutory scheme. Mr. Thomas was not engaged in acts related to production, advertisement, distribution, transportation, importation, receipt, and solicitation. The guidelines, then and now, do not make such distinctions or consider the obvious exceptions to such cases. The guidelines have not adjusted for the above material discrepancy.

As context, the 2012 study and report, U.S. Sentencing Commission concluded that the non-production child pornography sentencing scheme should be revised to account for emerging social science research and variations in an offender's culpability and for degree of sexual dangerousness.

The 2021 Commission report reiterates the following guidelines for a non-production offender with possession, with no allowance for psychologically lower culpability characteristics, or the concept of dangerousness of known one-third population of offenders, as follows:

Base offense level Possession:	<b>18</b>
With no intent to Traffic or Distribute:	<b>-2</b>
Enhancement. Under the age 12:	<b>+2</b>
Enhancement. Abuse of infant or toddler:	<b>+4</b>
Enhancement. Use of computer:	<b>+2</b>
Enhancement. Number of Images:	<b>+2</b>
Total:	<b>30</b>

The PLEA AGREEMENT with Mr. Thomas reiterates the same following guideline for a non-production offender with possession, with no allowances for psychologically lower culpability characteristics, as we have in Mr. Thomas case:

Base Offense Level, U.S.S.G. § 2G2.2(a)(1):	<b>18</b>
2G2.2(b)(2) - Material involved underage of 12:	<b>+2</b>
2G2.2(b)(4) - Material sadistic or masochist violence:	<b>+4</b>
2G2.2(b)(6) - Use of a computer or interactive service:	<b>+2</b>
2G2.2(b)(7) - 600 images or more:	<b>+5</b>
Acceptance of Responsibility:	<b>- 3</b>
Total Offense Level:	<b>28</b>

The PRESENTENCE REPORT for Mr. Thomas reiterates the same following guideline for a non-production offender with possession, with no incite to psychologically lower culpability characteristics as we have in Mr. Thomas case:

The base offense level:	<b>18</b>
Specific Characteristic. Minor under age 12:	<b>+2</b>
Specific Characteristics. Depictions of violence:	<b>+4</b>
Specific Characteristics. Use of a computer:	<b>+2</b>
Specific Characteristics. Over 600 images	<b>+5</b>
Acceptance of Responsibility:	<b>-2</b>
Assisted authorities' investigation or prosecution:	<b>-1</b>
<b>Total Offense Level:</b>	<b>28</b>

**CONCLUSION:**

For the facts set forth and reasoning accompanying Mr. Thomas' sentencing position, he respectfully asks this court to sentence him to a term of conditional probation, home confinement, supervised and electronic monitored release, under similar terms that have his proven compliance during pre-sentencing. 18 U.S.C. 3553.

**Respectfully Submitted,**

*matthew david kohn*

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**MATTHEW DAVID KOHN**

**Counsel of Record**

**George Thomas**

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EXHIBITS  
Forensic Psychological Reports



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November 23, 3034

Matt Kohn, Esq.  
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Santa Monica, CA 94043  
(310) 828-6116

**RE:** THOMAS, George  
**DOB:** 05/26/1982  
**Court Case No.:** CR 24-00384-01 HSG

### **FORENSIC EVALUATION REPORT: Mitigation**

*PRIVILEGED AND CONFIDENTIAL INFORMATION: The information contained in this report is intended only for the use of the individual to whom it was sent. It contains sensitive information that is legally protected under Section 952 of the Evidence Code. You may not copy, communicate, or transmit the information, or any abstract of the information contained in this report without the consent of the holder of the privilege of confidentiality.*

#### **REASON FOR EVALUATION:**

As a privately retained expert, I evaluated George Thomas on August 7 and August 21, 2024 to assess his mental status and history, determine his appropriate diagnos(es) if any, and identify any psychological factors that may have contributed to the offense<sup>1</sup>.

#### **FINDINGS**

- 1) Available data suggests the presence of Attention Deficit Hyperactivity Disorder and Unspecified Neurodevelopmental Disorder.
- 2) Mr. Thomas also meets diagnostic criteria for various mood, and anxiety, and personality disorders.
- 3) Certain vulnerability and destabilizing factors are relevant specifically to Mr. Thomas' offending behavior.
- 4) Mr. Thomas expresses remorse and has taken notable steps toward understanding and treating his pornography addiction.

#### **CONFIDENTIALITY LIMITATIONS & NOTIFICATION OF PURPOSE**

Mr. Thomas was informed of the purpose and non-confidential nature of the interview, as indicated above, as well as his right to refuse to answer questions. He was informed that a report would be generated that his attorney and possibly the Judge and District Attorney may have access to, and that I may be called upon to testify in court about the results of the evaluation. Mr. Thomas was advised of the possible limits of confidentiality and applicable reporting laws. Mr. Thomas was also informed that telehealth and/or videoconference<sup>2</sup> may be used as part of the evaluation, that the security of telehealth sessions cannot be fully guaranteed, and that he has the right to opt in or out of telehealth communication methods at any time.

<sup>1</sup> Please note I was not asked, nor did I conduct, a formal assessment of Mr. Thomas' risk of sexual reoffending.

<sup>2</sup> Telehealth: Variously dubbed telemedicine, teletherapy, distance therapy, e-therapy, internet therapy, or online therapy, "telehealth" is defined as the use of electronic transmission to provide interactive real-time mental health services. Telehealth is governed by all the same ethics and laws that cover in-office, in-person, face-to-face psychological service.

Mr. Thomas verbalized his understanding of this notice, was able to repeat back a general understanding, and agreed to proceed with the interview.

## **PROCEDURES OF EVALUATION & SOURCES OF INFORMATION**

### **Formal Interviews/Psychological Assessment Procedures:**

- August 7, 2024: Videoconference Mental Status Exam and Clinical Interview with Mr. Thomas from his residence in Hayward, California, lasting approximately 2 hours total.
- August 21, 2024: Supplemental Clinical Interview Questions with Mr. Thomas, again via videoconference from his residence, lasting approximately 45 minutes total.
- Completion of various assessment measures, including the following:
  - Beck Anxiety Inventory (BAI), *completed August 19, 2024*
  - Minnesota Multiphasic Personality Inventory – Third Edition (MMPI-3), *completed August 12, 2024*

### **Collateral Records Reviewed:**

- San Lorenzo Unified School District Assessment Report and Documentation, dated April 23, 1986;
- San Lorenzo Unified School District Psychoeducational Study, dated May 28, 1986;
- Mount Zion Hospital and Medical Center Speech and Language Consultation, dated September 10, 1987;
- United States District Court Criminal Complaint, dated April 24, 2023;
- United States District Court Application for a Warrant By Telephone Or Other Reliable Electronic Means, dated May 11, 2023;
- Kaiser Permanente Patient Health Summary, dated October 27, 2024;
- Confidential Psychological Evaluation, authored by Nicole Vienna, Psy.D., undated/currently being finalized; and
- Telephone consultation with Dr. Vienna, occurring on November 23, 2024.

## **IDENTIFYING INFORMATION & LEGAL CHARGES**

George Thomas is a 42-year-old (DOB: 05/26/1982) male who is currently charged with 18 U.S.C. §§ 2252(a)(4)(B) and (b), Possession of Child Pornography.

According to available records, Mr. Thomas was first interviewed by investigators on April 27, 2023. Mr. Thomas initially denied having any child pornography on his phone. The next day, Mr. Thomas called investigators saying he has received notices for the past approximate year that his phone number and some of his passwords were found on the dark web and this might be how his phone number came to be associated with child pornography. On May 11, 2024, officers executed a search warrant and seized a computer containing approximately 7,050 images of Child Sexual Abuse Material (CSAM) and approximately 7,733 videos of Child Sexual Abuse Material (CSAM).

## **FINDINGS & DISCUSSION**

### **1) Available data suggests the presence of Attention Deficit Hyperactivity Disorder and Unspecified Neurodevelopmental Disorder.**

#### **Discussion:**

Mr. Thomas reported a history of perinatal complications, including being born 2 months premature and subsequently spending some time in the NICU. From what Mr. Thomas recalled, his condition was serious and he was given a “50/50” chance of living as a newborn. There is a family history of Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder through Mr. Thomas’ brother and nephew, respectively.

While he did not recall if he had ever been formally diagnosed, Mr. Thomas expressed the belief that he has ADHD and potentially “dyslexia.” That is, Mr. Thomas reported he has difficulty focusing/paying attention, procrastinates, and is easily distracted. He also reported having difficulty learning to read and receiving special education for language and speech impairments. Indeed, available educational

records note Mr. Thomas was identified as “language-delayed” and “hesitant, shy, and difficult to understand” as early as age 4 (Psychoeducational Study, 05/28/1986). He was referred for speech therapy after an evaluation found language delays and that he “resists verbal expression” (Assessment Report and Documentation, 04/23/1986). When later evaluated at the Mount Zion Hospital Intensive Care Nursery Follow Up Program, Mr. Thomas was found to exhibit a “moderate general language delay with a more severe sound production disorder” (Speech and Language Consultation, 09/10/1987).

Due to Mr. Thomas’ reported language/communication deficits, social impairments, and history of special education for delayed speech, Mr. Thomas was subsequently referred to Dr. Nicole Vienna, Psy.D. for an assessment to rule-out Autism Spectrum Disorder. In an undated/currently being finalized report, Dr. Vienna further investigated Mr. Thomas’ speech and communication deficits, avoidance of social interactions, and difficulty making and maintaining friendships with standardized testing and further interview/evaluation. Among Dr. Vienna’s observations were the presence of language deficits, significant anxiety, sensory issues (including being sensitive to fabric, textures, and overwhelming sounds), and some restricted/fixated interests. Additionally, she noted Mr. Thomas’ father confirmed he was in resource specialist program (RSP) classes for the subjects of math, social studies, and reading.

Unfortunately, a major obstacle to understanding Mr. Thomas’ current diagnostic picture is the lack of reliable collateral data. Mr. Thomas’ mother, who passed away this year, was his primary and sole long-term relationship. She undoubtedly would have had a wealth of information about Mr. Thomas’ developmental functioning and trajectory that no other collaterals have. Though Dr. Vienna attempted to administer collateral testing to Mr. Thomas’ father, he was a limited historian and unable to provide historical information related to Mr. Thomas’ developmental years or observations as to his current functioning. While Mr. Thomas was eventually able to provide a few educational documents (referenced above), there is still limited developmental history available. In consultation with this writer, Dr. Vienna noted that the deficits Mr. Thomas currently endorses are shared with a variety of diagnoses and suggested “further cognitive assessment is recommended” to further clarify Mr. Thomas’ diagnosis and whether he meets criteria for a Learning or Language Disorder. Nevertheless, available educational documents and Mr. Thomas’ self-report indicate the presence of significant speech/language delays and poor social communication/social skills, consistent with an Unspecified Neurodevelopmental Disorder. Mr. Thomas has also exhibited attentional difficulties from an early age, for which he was recently formally diagnosed with Attention-Deficit Hyperactivity Disorder, Predominantly Inattentive Presentation (Kaiser Permanente Patient Health Summary, 10/27/2024).

**2) Mr. Thomas also meets diagnostic criteria for various mood, and anxiety, and personality disorders.**

**Discussion:**

Regarding his psychiatric symptoms, Mr. Thomas reported a history of depression dating back to his twenties when his parents divorced. Specifically, he endorsed symptoms of depressed mood, changes in sleep and appetite, isolating and withdrawing from others when “things get rough,” feelings of fatigue and loss of energy, and decreased positive experiences/anhedonia. While the severity of these symptoms has waxed and waned over the years, the symptoms have pervaded for longer periods (up to two to three years at a time) when there is the presence of an additional or external stressor, such as his parents’ divorce and/or his mother’s death. Mr. Thomas has also experienced passive suicidal ideation, or thinking that it might be better if he disappeared because “nobody would have to deal with it or be stressed out because of [him].” Mr. Thomas also has a longstanding history of anxiety. He experiences physiological symptoms of anxiety, including chest tightness, tingling, difficulty breathing, and fearfulness when faced with a trigger, such as social interactions, court dates, and/or importance work phone calls or meetings.

The results of various assessment measures similarly support the presence of psychopathology. Mr. Thomas was given the Beck Anxiety Inventory (BAI), a widely used 21 item self-report questionnaire developed for the assessment of symptoms corresponding to the criteria for anxiety disorders. His

score of 40 on the BAI places him in the Severe range of anxiety. His most prominent symptoms include fear of the worst happening, feeling dizzy or lightheaded, difficulty breathing, and feeling faint.

Mr. Thomas was also administered the Minnesota Multiphasic Personality Inventory – 3<sup>rd</sup> Edition (MMPI-3). The MMPI-3 is the third version of the Minnesota Multiphasic Personality Inventory, which was first developed in the 1930's. This tool is designed to provide a comprehensive and efficient assessment of clinically relevant variables. The most current/recent version of the test, the MMPI-3, features revised, updated, and new items; new and updated scales; and new normative samples that are more representative of the current adult population of the United States. Since its release in 2020, there have been numerous studies documenting the validity of the MMPI-3 in a variety of different settings and populations. The test also has several Validity scales which have been deemed effective in identifying over- and under-reporting. Recent peer-reviewed journal articles provide support for the use of the MMPI-3 in clinical and forensic settings (Ben-Porath, Heilbrun, & Rizzo, 2022).

Mr. Thomas's MMPI-3 Validity Scales indicate the presence of possible under-reporting on the protocol and a subtle attempt to present himself in a positive light by denying minor faults and shortcomings (L= 65). There was also indication of excessive cognitive/memory complaints as he endorsed cognitive/memory problems and difficulties in attention and concentration. In terms of emotional functioning, consistent with that reported during the interview Mr. Thomas endorsed a lack of positive emotional experiences and decreased interest in joyful or pleasurable activities. He also reported high levels of anxiety, including excessive worry, preoccupation with disappointments, and ruminations. His test protocol suggests these fears significantly restrict normal activity within and outside the home (BRF = 91).

There were no indications of maladaptive externalizing behavior or thought dysfunction in Mr. Thomas's protocol. However, Mr. Thomas reported being passive and submissive interpersonally. He reported not enjoying social events and being socially introverted, having difficulty forming close relationships, and emotional restriction. He also reports being shy, easily embarrassed, and uncomfortable around others. Diagnostic considerations suggested by the MMPI-3 protocol included disorders related to attention difficulties, anxiety disorders/disorders involving excessive worry, and Avoidant Personality Disorder.

During subsequent follow-up interview, Mr. Thomas confirmed his cognitive/memory complaints primarily refer to his attention difficulties, which include what he described as a habitually "wandering" mind and thoughts that are "all over the place." As previously mentioned, Mr. Thomas was referred to Kaiser Permanente for an assessment of his attentional difficulties and has subsequently been formally diagnosed with Attention-Deficit Hyperactivity Disorder, Predominantly Inattentive Type, and prescribed Adderall XR 5 mg.

Consistent with that noted on the MMPI-3, during the clinical interview Mr. Thomas described significant challenges in his interpersonal functioning. He stated,

*"I wasn't really good at being social, I was more of a social awkward person. I did have friends I'd made in the past that would stop talking to me because I was so awkward to them... I think that for me the rejection was kind of the worst because it kind of made me feel like a nobody, I guess. I didn't want to have to keep going through that."*

Throughout the interview Mr. Thomas espoused themes of shyness, low self-esteem, and social inhibition. His fears seem to center particularly around pervasive feelings of inadequacy and hypersensitivity to criticism. To that end, Mr. Thomas reported having very few long-term relationships, whether romantic or social. He remarked that he has only had one romantic relationship with a woman, which occurred approximately 10 years ago. His primary support as an adult was his mother, who unfortunately passed in March 2024. In discussing this, Mr. Thomas reported he desires to have more meaningful social and romantic relationships but struggles to know what to say or how to act in social settings. He then feels socially awkward or "different," which causes him to withdraw and isolate.

Finally, Mr. Thomas tends to blame himself for unrelated occurrences of events. For instance, throughout the present contacts Mr. Thomas reported he always wondered if he somehow was to blame for his parents' divorce as well as his mother's recent passing, stating, "I'm wondering if my actions could have caused my mom's death... the stress from this, like leading up to everything, I wonder if it was because of me that she passed, if it caused stress on her heart."

In total, Mr. Thomas is an individual with longstanding history/pattern of social inhibition, feelings of inadequacy, and hypersensitivity to rejection (or even the perception of rejection). These overall characteristics appear to be lifelong and present in a variety of contexts (occupational, education, social, etc.), consistent with a diagnosis of Avoidant Personality Disorder. The diagnostic criteria<sup>3</sup> Mr. Thomas exhibits (and of which 4 are required to merit the diagnosis) are:

- Is unwilling to get involved with people unless certain of being liked;
- Is preoccupied with being criticized or rejected in social situations;
- Is inhibited in new interpersonal situations because of feelings of inadequacy;
- Views self as socially inept, personally unappealing, or inferior to others;
- Reluctant to take personal risks or to engage in any new activities because they may prove embarrassing;

Individuals with Avoidant Personality Disorder avoid making new friends unless they are certain they will be liked and accepted without criticism. Interpersonal intimacy is often difficult for these individuals and they tend to be shy, quiet, and inhibited. Like most people with Avoidant Personality Disorder, Mr. Thomas has become isolated and lacks an extended support network. Indeed, even attempting to speak with various family members and supports as part of the present evaluation(s) was a challenge due to the superficial and/or absent nature of longstanding, meaningful relationships.

As previously mentioned, Dr. Vienna and I both considered whether Mr. Thomas' deficits in social communication and interactions were possibly due to his neurodevelopmental disorder and/or autism spectrum disorder traits. Mr. Thomas has clear impairments in his ability to develop, maintain, and understand relationships as well as a history of speech delays, impairments and special education. However, both Dr. Vienna and I agree that while Mr. Thomas appears to have a Neurodevelopmental Disorder (present diagnosis offered being Unspecified Neurodevelopmental Disorder), his anxiety and personality traits extend beyond that expected for Neurodevelopmental Disorder alone. Put another way, Mr. Thomas appears to merit a Neurodevelopmental Disorder *and* anxiety, mood, and personality disorder diagnoses.

On that note, Mr. Thomas has a longstanding history of depression and anxiety. That is, he has had periods of depression lasting up to two years and which have consisted of 5 or more symptoms of depression, thereby meeting criteria for Major Depressive Disorder, Recurrent, Moderate. Mr. Thomas is also currently experiencing high levels of anxiety. Tests administered in the course of the present evaluation (including both the Beck Anxiety Inventory and the MMPI-3) revealed Severe levels of anxiety, excessive worry, and preoccupations with disappointments. These symptoms exceed three symptoms of anxiety occurring more days than not for 6 months, and which altogether restrict Mr. Thomas' behavior both within and outside of the home. Thus, a diagnosis of Generalized Anxiety Disorder is appropriate.

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<sup>3</sup> American Psychiatric Association. (2022). Personality Disorders. In *Diagnostic and statistical manual of mental disorders* (5<sup>th</sup> ed., text rev.).

In summary, Mr. Thomas meets full diagnostic criteria for the following DSM-5-TR Diagnoses:

F60.6	Avoidant Personality Disorder
F89.0	Unspecified Neurodevelopmental Disorder
F41.1	Generalized Anxiety Disorder
F90.0	Attention Deficit Hyperactivity Disorder, Predominantly Inattentive Presentation, <i>by history</i> <sup>4</sup>
F33.1	Major Depressive Disorder, Recurrent, Moderate

**3) Certain vulnerability and destabilizing factors are relevant specifically to Mr. Thomas' offending behavior.**

**Discussion:**

Research on child pornography offending typically occurs in small groups with much heterogeneity in offenders. Thus, it is difficult to generalize about a "typical" child pornography offender, and risk management strategies are best tailored to each offender's individual vulnerability and risk factors. In Mr. Thomas' case, the present evaluation identified certain behaviors and traits that contributed to his child pornography use that have been identified in research (Houtepen, Sijtsema, & Bogaerts, 2014<sup>5</sup>).

As described above, Mr. Thomas has longstanding difficulties with depression and anxiety. It appears his pornography use has been a coping mechanism for pervasive feelings of loneliness and isolation.

Mr. Thomas also reported intimacy deficits and loneliness. He admitted to never having sexual contact with either an adult male or female. Specifically, Mr. Thomas reported having only one romantic relationship, which occurred nearly 10 years ago. He never had sex with this partner. When asked how he learned about sex, Mr. Thomas replied that sex was not discussed with him by either of his parents and he first learned about sex by viewing pornography. As described elsewhere in this report and consistent with his Avoidant Personality Disorder diagnosis, Mr. Thomas described himself as a "socially awkward person." While he desires connectedness and relationships with others, he "stopped trying" to have relationships because he didn't want to "keep going through [the rejection]."

As is common amongst child pornography offenders, Mr. Thomas also demonstrates traits of pornography/internet addiction. In his early to mid-thirties Mr. Thomas began viewing pornography on a more regular basis. He described this as a "kind of release" for stress and an "escape from reality." During this period of time Mr. Thomas viewed pornography at least once daily. He became somewhat obsessed with viewing pornography, to the point that he would think about it throughout the day at work. Pornography became his primary "focus" and detracted from in-person socializing. Mr. Thomas reported, "I kind of got so caught up on it that you just click on whatever. And that's when I kind of realized it was a big problem." Mr. Thomas reported he had difficulty reducing his pornography use and that it impacted various aspects of his life.

Research has found that such prolonged engagement with the internet is associated with a decline in offline contact with people, as Mr. Thomas reported. Additionally, prolonged online engagement also leads to habituation and heightens the need for more illicit material to reach satisfaction (Houtepen, Sijtsema, & Bogaerts, 2014).

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<sup>4</sup> By history indicates that this diagnosis was offered by another qualified provider and available data suggests this diagnosis remains appropriate/applicable.

<sup>5</sup> Houtepen, J. A., Sijtsema, J. J., & Bogaerts, S. (2014). From child pornography offending to child sexual abuse: A review of child pornography offender characteristics and risks for cross-over. *Aggression and violent behavior*, 19(5), 466-473.

- 4) **Mr. Thomas expresses remorse and has taken notable steps toward understanding and treating his pornography addiction.**

**Discussion:**

Throughout the present interviews Mr. Thomas invariably described his child pornography usage as problematic. He stated, "I feel very bad about it. It's something that I never saw myself getting into, but it happened unfortunately... I don't know how to make that right, but I want to." Mr. Thomas admitted that the charges and his actions are very difficult to talk about because he has since realized "how bad it is, and bringing it back to my memory just makes me sick to my stomach per se." He expressed the belief that child pornography is wrong because "regardless of whether the person seemed to like it or not, it doesn't matter... It's a younger person, they were manipulated into it. It's still abuse." Perhaps even more notable was Mr. Thomas' surprise when I proposed possible triggers and precipitants to his pornography use. Mr. Thomas repeatedly stated, "I don't think I've ever actually sat down and thought about it on this level... it's helping me understand a little bit better [what happened]." He appeared to be genuine in his desire to understand himself better to both prevent further criminal offenses and to improve his overall quality of life, and never displayed any defensiveness or rigidity. Moreover, Mr. Thomas has a positive attitude toward interventions that have been recommended both by the probation department and by Dr. Vienna and myself. He is currently participating in group psychotherapy, is on the waitlist for individual psychotherapy, and has participated in various interventions to obtain diagnostic clarity, including participating in various testing and evaluations. Altogether, these factors bode well for his future response to treatment.

**SUMMARY/CONCLUSIONS**

The present evaluation reveals Mr. Thomas meets full diagnostic criteria for Avoidant Personality Disorder, Unspecified Neurodevelopmental Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, and Attention-Deficit Hyperactivity Disorder (ADHD). Though he has a documented history of special education for his learning and language difficulties, Mr. Thomas has no prior criminal history, is employed, and has stable housing. Thus, Mr. Thomas lacks many of the general psychological characteristics known to be related to antisocial behavior and reoffense, such as impulsivity, prior criminal acts, and low victim empathy.

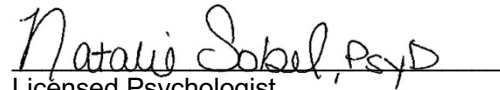
However, Mr. Thomas has a constellation of symptoms, language deficits, and personality characteristics that have rendered social interaction highly uncomfortable and anxiety-provoking for him. These deficits have been present from a very young age and have made communication with others very difficult and labored. Due to his increasing anxiety in adulthood, Mr. Thomas further withdrew from interpersonal interaction. Over time, his isolation and mood/anxiety concerns – coupled with a lack of effective coping mechanisms/insight – culminated in a pornography addiction. As someone who was terrified of rejection or humiliation from others, pornography provided a stress-free way for Mr. Thomas to meet intimacy needs and relieve stress/loneliness. Throughout the present interview Mr. Thomas did not exhibit any defensiveness or try to justify or rationalize his pornography use but appeared genuinely interested in understanding himself better and engaging in treatment.

It is recommended Mr. Thomas participate in individual therapy to accommodate and explore his communication and thought patterns. Group therapy related to social skills building is also recommended and Mr. Thomas has been referred to several online social skills and anxiety therapy groups. Mr. Thomas may also benefit from a psychotropic medication evaluation to target his mood and anxiety symptoms. Finally, Mr. Thomas should complete Dr. Vienna's recommended cognitive/neuropsychological testing to assess his informational processing abilities and better understand his cognitive strengths and weaknesses.

Please note, any forensic evaluation is only as good as the information on which it is based. Missing information may adversely affect the reliability of any findings or opinions. If new or potentially relevant information comes to light, please contact me so that I can determine whether this new information would lead to substantive changes in my findings or opinions on this matter.

Thank you for the opportunity to evaluate this defendant. Should you or the Court have any additional questions, please do not hesitate to contact me.

By:

A handwritten signature in black ink that reads "Natali Sobel, PsyD". The signature is written in a cursive style and is positioned above a horizontal line.

Licensed Psychologist

Sobel Psychological Group, APC

Clinical & Forensic Psychology

Member, Los Angeles County Superior Court Panel of Approved Psychologists

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## George Thomas

Patient Health Summary, generated on Oct. 27, 2024

### Patient Demographics - Male; born May 26, 1982

Patient Address	Patient Name	Communication
Former (Jan. 22, 2005 - Jan. 15, 2018): 824 BLOSSOM WAY (Home) HAYWARD, CA 94541-2004	George Thomas	510-224-8141 (Home) 510-224-8141 (Work) 510-224-8141 (Mobile) georgedavidthomas@gmail.com
(Jun. 29, 2018 - ): 824 BLOSSOM WAY (Home) HAYWARD, CA 94541-2004		
Language	Race / Ethnicity	Marital Status
English - Spoken (Preferred) English - Written (Preferred)	White / Unknown	Unknown

### Note from Kaiser Permanente Northern California

This document contains information that was shared with George Thomas. It may not contain the entire record from Kaiser Permanente Northern California.

### Allergies

Not on File

### Medications

**Dextroamphetamine-Amphetamine (ADDERALL XR) 5 mg Oral 24hr SR Cap** (Started 10/15/2024)

Take 1 to 4 capsules by mouth daily as needed

### Active Problems

Problem	Noted Date	Diagnosed Date
ADHD, PREDOMINANTLY INATTENTIVE PRESENTATION	10/15/2024	

### Immunizations

**COVID-19 PF (Janssen/J&J)** (Given 12/16/2021)

**HBV (Hepatitis B)** (Given 2/28/1995, 8/31/1994, 7/22/1994)

### Social History

Tobacco Use	Types	Packs/Day	Years Used	Date
Smoking Tobacco: Never				
Alcohol Use	Standard Drinks/Week			
Not Asked	0 (1 standard drink = 0.6 oz pure alcohol)			
Substance Use	Types	Use/Week		
Not Asked				
Sex and Gender Information	Value		Date Recorded	
Sex Assigned at Birth	Not on file			

Component	Value	Ref Range	Test Method	Analysis Time	Performed At	Pathologist Signature
Opiates, urine, screening	UNDETECT	UNDETECT			TPMG REGIONAL LABORATORY, MWS	
Amphetamines, urine, screening	UNDETECT	UNDETECT			TPMG REGIONAL LABORATORY, MWS	
Cocaine, urine, ql	UNDETECT	UNDETECT			TPMG REGIONAL LABORATORY, MWS	
THC, urine, screening	UNDETECT	UNDETECT			TPMG REGIONAL LABORATORY, MWS	
Benzopines screen, urine, qual	UNDETECT	UNDETECT			TPMG REGIONAL LABORATORY, MWS	
<div>Comment:</div> <div>This test was developed and its performance characteristics determined by TPMG Regional Laboratory. It has not been cleared or approved by the FDA. The laboratory is regulated under CLIA as qualified to perform high-complexity testing. This test is used for clinical purposes. It should not be regarded as investigational or for research.</div>						
Barbiturates,ur,ql	UNDETECT	UNDETECT			TPMG REGIONAL LABORATORY, MWS	
<div>Comment:</div> <div>The Urine Barbiturate Screen tests for the presence of Phenobarbital and for intermediate (Amobarbital, Butalbital) and short-acting (Pentobarbital,Secobarbital, Butabarbital) barbiturates.</div>						
Ethanol, urine, ql	UNDETECT	UNDETECT			TPMG REGIONAL LABORATORY, MWS	
Oxycodone,ur,ql	UNDETECT	UNDETECT			TPMG REGIONAL LABORATORY, MWS	
<div>Comment: The urine Oxycodone cut-off for detection is 100 ng/mL.</div>						
<div>Comment, drug panel 1, SEE NOTE</div> <div>urine</div>					TPMG REGIONAL LABORATORY, MWS	

Formatting of this note is different from the original.

## CPT NOTE FOLLOW-UP

Any use of this report for purposes other than evaluation for ADHD may be a violation of ethical principles and the author cannot be responsible for circumstances or damages that may result from such unauthorized use.

Service Location: Telephone

Review, Interpretation Test Results Time: 18 min

Time spent with pt: 9 min

### Discussion:

Discussed the results with pt, reflecting scores that do suggest a disorder characterized by attention deficits, of ADHD. Reviewed the complexities of the etiology of ADHD, and that this data is not used solely for diagnostic purposes but with a detailed clinical evaluation. Reviewed treatment options, agreed to online ADHD classes and MD eval.

### Tests Administered:

Conners Continuous Performance Test 3rd Edition

### Test Data:

George completed the CPT 3 under the direction of Maria Silva MA as part of the ADHD work up. The raw statistical breakdown is as follow:

Inattentiveness (Detectability, Commissions,Omissions, HRT, HRT SD, and Variability): SLOW of a T-score: 69  
Impulsivity (HRT, Commissions, and Preservations) : ELEVATED (preservations not likely to impulsivity) of a T- score: 61  
Sustained attention (HRT Block Change, Omission and Commissions by block): LOW of a T-score: 36  
Vigilance (HRT Inter-stimulus ISI interval Change, Omissions and Commissions by ISI): AVERAGE of a T-score: 52

### Clinical Interpretation of the Scores:

\* George's performance was noteworthy for being markedly inaccurate, suggestive of impairments in quickly and effectively perceiving or processing stimuli with some indication (Detectability, Commissions,Omissions, HRT, HRT SD, and Variability).

Overall, George's profile is associated with a moderate likelihood for significant attention disorder, such as ADHD; with a total of 2 atypical T-scores. However, it is also possible that George's attention problems are due to another etiology, such as a mood disorder, anxiety, life stress or other factors. These factors should be ruled out prior to making a diagnosis of ADHD.

\*\*It must be noted that these test results are not to be used solely in making an ADHD diagnosis but must be used in conjunction with a thorough clinical evaluation.

### Future Appointments:

Future Appointments

### Appointment Date & Time Visit Type Provider Department/Facility

Oct 08, 2024 4:00 PM PDT MH Online Class Visit ACT SKILLS GROUP-TUE ADULT PSYCHIATRY (STR-COTTLE ROAD-STRB)

Oct 15, 2024 10:00 AM PDT MH Video Visit Basin, Lev (M.D.) ADULT PSYCHIATRY (STR-COTTLE ROAD-STRB)

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Genevive Julien, PSYD  
Psychologist  
Department of Psychiatry  
Kaiser Permanente San Jose MC

Electronically signed by GENEVIVE JULIEN PSYD at 10/08/2024 12:25 PM PDT